

## Gaining acceptance: Discourses on training and qualifications in peer support

*Anne Scott*

### **Abstract**

The debate relating to formal qualifications for peer support in mental health reflects conflicting ideas about the nature of this new occupation. Three discourses among peer supporters/peer support managers in New Zealand are identified in relation to training and qualifications. The health professionalism discourse sees peer support as a set of tools which can be developed through education and training. The grassroots discourse holds onto the non-hierarchical, nonprofessional and inclusive nature of peer support as a form of relational 'common sense'. The transformational peer support discourse sees peer support training as potentially instigating radical revisioning within one's life journey. While seeing peer support training as crucial, its proponents are circumspect about formal qualifications in mental health. This article identifies these three discourses, discusses them in relation to the development of peer support as a new occupation, and draws a comparison with the professionalisation of counselling in the 20th century.

**Keywords:** Mental health; peer support; New Zealand; discourse analysis; qualifications; credentialing

### **Introduction**

The creation of new occupational groups in health care is an ongoing phenomenon (Timmons, 2011: 338). However, peer support is also a new type of occupation in mental health, in which paid or funded volunteer services are provided by people who are, or have been, service users themselves (Clay, 2005; Orwin, 2008; O'Hagan, McKee and Priest, 2009). It had its origins in the self-help movement (Archibald, 2007) and the mental health consumers movement (Chamberlin, 1977; Campbell, 2005) in the context of deinstitutionalisation during the 1970s and 1980s. In particular, peer support developed in the context of two different movements operating in the wealthier English speaking countries in the 1970s. These included the reformist self-help/

mutual aid movement, which focused on personal support complementary to the medical system, and the more radical mental health consumers/psychiatric survivors' movement (Everett, 1994; Nelson et al., 2008: 193). Within the consumers/survivors movement, peer support emerged as a key part of a liberation agenda (Chamberlin, 1977; Campbell, 2005: 19; Adame and Leitner, 2008).

Judi Chamberlin (2004) has described the way peer support emerged in Canada and the United States as consumers, psychiatric survivors and mental patients began organising informally, and discovering that they could provide support that addressed each other's unmet needs. This was accomplished in spite of discouragement for such horizontal relationships by the mental health system (Chamberlin, 2004). Similarly, in Aotearoa New Zealand, peer support first emerged in the 1970s as an informal arrangement of ex-patients visiting, and providing support to, current patients on a voluntary basis.

Peer support as offered by the consumer/survivor movement had a rather oppositional relationship with the mainstream mental health system. As Mead, Hilton and Curtis argue, it saw 'recovery' as undoing the cultural processes by which people develop careers as mental patients (2001: 135-136). Psychiatric labels were thus discouraged; peer supporters instead encouraged their peers to talk about the experiences themselves, and thus to normalise experiences of extreme mental distress (Chamberlin, 2004; Adame and Leitner, 2008: 149). They strove to minimize hierarchy and to encourage mutuality in relationships (Chamberlin, 2004; Mead and MacNeil, 2006). Choice and empowerment were cornerstone principles, in response to a sometimes coercive mainstream mental health system (Campbell, 2005; Clay, 2005).

During the past twenty years, peer support has been moving into the mainstream of mental health provision. In developed Anglo-Saxon countries, it is now often funded by the public sector and provided by paid workers (Bradstreet, 2006; O'Hagan et al., 2009). This has been driven by the development of the 'recovery' approach (Deegan, 1988; Anthony, 1993), and its institutionalisation in the mental health systems of many liberal democracies (Ontario Ministry of Health, 1993; Mental Health Commission, 1998; President's New Freedom Commission for Mental Health, 2003; Scottish Executive, 2006). At the same time, the consumers movement which gave it birth has become larger, more diverse and generally more pragmatic and reformist, even while the links between the consumers' movement and peer

support are becoming somewhat attenuated. These developments, along with a shift towards consumerist models in healthcare more generally, have led to a willingness to experiment with funded peer support. A meta-review of the evidence found that peer support is at least as effective as other forms of mental health provision (Doughty and Tse, 2011).

Peer support now takes place in a broad diversity of forms and through a wide variety of organisational structures. In Aotearoa New Zealand, most peer support involves a former service user walking alongside a person currently undergoing mental distress. It might involve facilitating support groups; producing educational programmes; doing advocacy; providing face-to-face mentoring; providing safe accommodation for people in crisis; running drop-in centres; supporting people to find employment or housing; visiting inpatients; operating telephone support lines; or providing activity programmes. Much peer support is provided through community based NGOs or small business, although some is provided through mainstream mental health services. Most peer support in Aotearoa New Zealand is funded through a combination of public funding provided by District Health Boards and voluntary sector fundraising. All peer support in Aotearoa New Zealand draws on a common set of values, which have been recently articulated as mutuality; the value of experiential knowledge; self-determination; participation; equity; recovery and hope (Te Pou, 2014a: 4). These values mean that peer supporters will not engage in coercive practices or restraint of clients within the workplace.

This article focuses on the attempts by peer supporters and peer support leaders to gain legitimacy with clinicians and funders as a new health occupation, particularly as these relate to calls for a national qualification in peer support in New Zealand and to advocacy for greater levels of educational accreditation amongst peer supporters. Larson argued in the 1970s that it is an occupation's technical knowledge which enables it to persuade the State to license and protect it (Timmons, 2011: 339). It is on this basis that occupations are able to claim some autonomous area of practice, and the respect of other stakeholders. This is a problematic requirement for peer support, which has been based from the start on a rejection of technical expertise in favour of an identity-based claim to legitimacy through lived experience.

Recently, there have been active attempts by peer support leaders and consumer advocates in the New Zealand mental health sector to develop a national qualification in peer support and to require the accreditation of all peer

support workers. While these attempts have so far not resulted in a national peer support qualification – beyond the organisationally based qualification offered by one peer support provider – they have resulted in the development of national standards and a set of peer support competencies which are expected to inform job descriptions, training curricula, quality assurance procedures, service specifications, performance management and auditing (Te Pou, 2014a; 2014b). These recent developments have been hotly debated within the peer support sector, and have been approached with a mixture of enthusiasm and trepidation. In this article, I will explore three discourses articulated around the standardisation of training and qualifications by peer supporters and peer support managers in Aotearoa New Zealand. How does the development of national educational standards dovetail with the historical constitution of peer support?

In a classic paper, Valerie Fournier (1999) argued that professionalism and expertise play a role in governmentality. In order to achieve the legitimisation which goes with professionalisation, occupations must conduct themselves with ‘competence’ as defined by the concerns, norms and values of other, socially powerful, actors. In so doing, they discipline themselves. Drawing on a Foucauldian analysis, Fournier suggests that domination intersects with ‘technologies of the self’ (1999: 283). In the process, occupations come to be constituted in ways that align with socially powerful discourses. A discontent with professionalisation among many occupations such as alternative health practitioners has thus been associated with a fear of the loss of independence and autonomy to practice in a manner at odds with dominant paradigms (Timmons 2011: 338). Peer support is moving into a period of occupational development, rather than professionalization. However, I will argue in this article that it is such fears, regarding the possibility that the disciplining effects of occupational development might strip away the essence of peer support that generates the disquiet many peer supporters feel about the trend towards greater accreditation of peer support practice.

## **Methodology**

The data used in this article were collected in a descriptive study of peer support services in Aotearoa New Zealand in 2010. A listing was made of every organisation in Aotearoa New Zealand funded by a District Health Board which at that time offered a peer support service. Approximately 60 organisations were

identified. Purposive sampling was then used to choose ten organisations offering peer support; this amounted to fourteen peer support services, given that some organisations offered more than one peer support service. Sampling was done in such a way as to reflect the population distribution around the country; there were seven organisations chosen in various parts of the North Island and three in the South Island, a division which roughly reflects the spread of population in Aotearoa New Zealand. Sampling also ensured that both urban and rural areas were included, and considered diversity in terms of the type of organisation offering peer support, the type of service offered, the model of peer support being employed, and the size of the organisation and service. All fourteen services invited to participate agreed to do so.

Peer support services included in the study offer a variety of types of peer support, including one-on-one peer mentoring, support groups, Kaupapa Māori peer support, intensive peer support for people leaving long term hospital care, drop-in centres, advocacy, support to inpatients, telephone support lines, and crisis houses. There were a number of organisational structures included. Four of the peer support services were based in small consumer-led trusts. Two services were based in a consumer-led business. One service was located with a District Health Board's Specialist Mental Health Services arm. The rest of the services were based within larger mental health trusts offering a variety of services, including consumer-led services. Several of these organisations have been offering peer support for up to twelve years, although a period of four to five years was more common. All of the peer supporters and peer support managers we interviewed held paid positions, with the exception of one manager whose position was unfunded, and two volunteer peer supporters in one of the Kaupapa Māori services.

It is important that knowledge about indigenous people's services is collected and analysed within an indigenous framework (Smith, 1999). Thus, different data collection strategies were used for the twelve mainstream services and the two Māori orientated services. In the twelve mainstream services, the author visited each service over two to three days, and spent informal time in the office. Semi-structured interviews were conducted with a peer support manager and one or more peer supporters on the staff. Participants were chosen by the organisations themselves. Two in-depth interviews, focusing respectively on peer support relationships, and policy and practice, were conducted with each participant. This process involved 24 participants in total.

In the two Kaupapa Māori services, a tikanga-based methodology was used. Tamehana Consultants, who have expertise in Māori mental health, designed a process that involved two day visits by themselves and a Māori researcher to each service. During these visits, unrecorded whakatau and mihi<sup>1</sup>, which are designed to build relationships, were followed by several recorded group interviews, similar to focus group interviews, which included peer support managers, peer supporters, kaumatua, clinical supervisor and volunteers in the two services. Thirteen participants took part in these group interviews. There were thus 37 participants in total. All names given are pseudonyms, and identifying details have been changed.

The interview transcripts were coded through 67 themes expressed by participants. Some of these were generated by interview questions, and others emerged inductively from the data in a process of bottom up coding to identify recurring themes (Strauss, 1987). Themes related to ways of conceptualising peer support, to practice issues, to benefits of peer support, to relationships with clinical services, and to policy issues. In this article, the areas of policy issues and the conceptualisation of peer support are the focii, with the codes of training, qualifications, professionalism and ‘what is peer support?’ being most central.

I engaged in a Foucauldian discourse analysis relating to the talk coded at these nodes. As Willig notes, within a Foucauldian approach, discourses are seen as sets of statements that construct objects and subject positions; they thus constrain what can be said by whom, and how it can be said (Willig, 2008: 112). Discourses are bound up with institutional practices, and they thus play a major role in legitimating – or in the case of counter-discourses in challenging – entrenched power relations. Subject positions, which involve becoming located within a structure of rights and obligations by using a discursive repertoire (Willig, 2008: 116) can lead to one seeing the world from the vantage point of a particular position.

I engaged in the form of discourse analysis elaborated by Carla Willig (2008). This involved recording the discursive constructions of the objects ‘training’, ‘qualifications’ and ‘peer support’, and then looking for patterns in these constructions to identify discourses which were operating. I explored what was gained by constructing these objects within each of the discourses

---

<sup>1</sup> A whakatau is a welcome, while mihi combine personal introductions with connections on the basis of whakapapa.

identified, and looked at the subject positions enabled or facilitated by each discourse. I then looked at the relationship of each discourse to practice. My major concern in this article was to identify the discourses operating in regards to qualifications in the talk of peer supporters and peer support managers in Aotearoa New Zealand. I looked at the way these were tied up with power relations around credentialing and acceptance for the new occupation of peer support, and explored the ways that participants drew on these differing discourses to construct subject positions for peer supporters and for peer support itself.

Credibility of the analysis was assisted by presenting this article to members of the peer support community for comment before submission. Careful records have been kept of each phase of the research process to assist in the research's dependability. The research was approved by the Multi-Regional Health and Disability Ethics Committee of Aotearoa New Zealand.

## **Analysis**

Three differing discourses were identified in relation to qualifications, training and occupational development for peer supporters. The first, 'health professionalism', is a hegemonic discourse in the health sector, and most participants spoke to it in some fashion, although very few located themselves within it in an uncomplicated fashion. The second discourse, which I have called the 'grassroots discourse', challenges health professionalism, while also existing in an uneasy tension with it. The third discourse, which I have dubbed 'the transformational peer support discourse', involves a more thoroughgoing challenge to the philosophical basis of health professionalism, although it also involves practices which might be seen to be moderately close to the pursuit of educational qualifications central to this approach. Participants drew on these differing discourses to negotiate strikingly different subject positions, and to construct peer support in quite different ways. This article suggests that the occupational development debate within peer support is partially driven by quite different understandings of what peer support is, and of where it should be going.

### *The health professionalism discourse*

The health professionalism discourse is found in various forms throughout the health sector. It sees health work as performed by technically skilled, knowledgeable and capable individuals, whose competence is assured by their

acquisition of educational qualifications. Knowledge is equated with expertise, and thus with competence to practice. Personal experience, life experience and subjective understandings hold an inferior value within this discourse if, indeed, they are present within it at all. Practical experience is valued within this discourse, but is held to be secondary to the holding of the appropriate qualifications, which enable one to practice safely. Some of the participants articulating this discourse came from an organisation offering an NZQA level 4 Certificate<sup>2</sup> in peer support, and requiring all of its peer supporters to complete this certificate. When asked if she thought this shift towards requiring qualifications for peer supporters was helpful, a peer supporter from this organisation said, “Yeah, I do. You want to have people that are competent” (PSW 1). She understood competence, however, within the strengths based philosophy which underlies this organisation’s approach, which does not sit easily within a mainstream health professionalism discourse<sup>3</sup>.

Some participants drawing on this discourse used the metaphor of the toolkit to conceptualise the relationship and awareness skills taught within peer support education as just that... skills. They could be mixed with standard mental health work approaches as taught within the Mental Health Support Workers’ Certificate and other forms of mental health education.

In the past, peer support has probably thought that by learning the mental health certificate you’re going to end up with a different philosophy than what peer support is about. But I don’t think that is necessarily true. They’re both for the good of the people. So if one of those tools isn’t one that you necessarily think is the best one to use... you will take some of those tools, and take some of those ones and take some of those ones, and blend them together to use them for the best. And if one tool isn’t working, you pop out another one. So the more education, and the more understanding you have of the whole picture, I think, the better (PSW 2).

This approach sees peer support education as one form of technical knowledge to be combined with other forms of technical knowledge in order to create a

---

<sup>2</sup> New Zealand Qualifications Authority Level 4 Certificates are the lowest level of formal post school qualifications. They require no pre-qualifications for entry and generally take one year to complete. This philosophy focuses on the autonomy of individuals and on supporting self-determination within a framework that emphasises individual strengths rather than deficits/pathology

<sup>3</sup> This philosophy focuses on the autonomy of individuals and on supporting self-determination within a framework that emphasises individual strengths rather than deficits/pathology



more competent practitioner. Should a combined qualification for all mental health workers be created which incorporated peer support and recovery principles, as advocated by one manager (Mgr. 1), it might take this form.

A peer supporter from a service which took all its workers through at least a Level 4 Mental Health Support Workers qualification, noted that a lack of proper training and support at other services could expose the entire peer support sector to risk:

You've got to have that right training and the right support all the way through, constantly, you know, and that does worry me. All the good work that people do, you know it is noticed. It is noticed. But all you need is the occasional person that becomes sick and then goes up and really stuffs up. You know, at the unit or wherever else, and those are the times that are really remembered (PSW 3).

By raising the possibility that a mentally unwell peer supporter might bring peer support into disrepute by going to work at the hospital when not well enough to conduct themselves there responsibly, he conflates educational background with the ability to manage one's own mental illness reliably. This raises the spectre of clinicians who feel that peer support is too risky, because peer supporters are untrained, unprofessional and liable to become unwell. Anecdotally, this is quite a common belief amongst mental health clinicians in Aotearoa New Zealand; it was raised as a major issue by peer supporters and managers from both crisis houses involved in this study. It is the use of the health professionalism discourse which locates unqualified peer supporters as 'risky' in this way. Educational qualifications thus come to represent the ability to behave professionally and to maintain self-control at all times. As Fournier notes, competence is indexed not just in terms of mastery of a body of knowledge, but also in terms of appropriate conduct (1999: 286).

The good opinion of clinicians and funders is extremely important to peer supporters and peer support managers. Indeed, it was spontaneously mentioned as one of the most important issues for peer support by over half the participants in the study. Credibility with these important players is seen by many to depend on having qualifications, and thus on playing to the health professionalism discourse:

That's something that they could at least say that they have, is a certificate in peer support to validate what they do. And to keep any critics at bay that might say, "Well, where's this bit of paper that says you're qualified at what you do?" Because that happens as well. (Mgr. 2).

Credentials are sources of power for individuals, effectively blocking substantive judgements about their actual performance and abilities (Brown and Bills, 2011: 135). The pressure thus created to move towards credentialing peer support is powerful, and many participants at least made mention of a push for greater qualifications as a trend within the peer support sector. In the guide for planners and funders which accompanies the new Aotearoa New Zealand set of competencies for peer support workers, it is noted that the Ministry of Health's new mental health and addiction services plan expects peer support education and training programmes to be put into place by providers (MoH, 2012; Te Pou, 2014b). The Competencies document also recommends development of a national peer support qualification, along with revised service specifications, career pathways, and development of new peer practice tools (Te Pou, 2014b). However, the subject positions open to peer supporters within this discourse are not attractive. At best, a well-qualified peer supporter can speak with authority which plays catch up to that of his or her very well qualified counterparts in other parts of the mental health sector. More commonly, however, peer supporters are seen as unqualified, untrained and are thus located in an inferior, risk-bearing, position. This is a position which in some ways recapitulates the stigma to which mental health consumers are subject. Participants responded to this positioning in a variety of ways. A very small number embraced this discourse; however, most participants had more complex responses to a discourse that challenged their status as health workers.

These included fear. One manager, on receiving information about this research study, initially interpreted it as related to a wider attempt to require greater credentialing for peer supporters, and reacted with alarm (Mgr. 2). Other participants responded defensively to any hint of the health professionalism discourse. When a question about the value of qualifications was raised in the interviews, many participants responded by listing their own educational qualifications, or those of their staff; these might include anything from accountancy, to teaching, to counselling, to the mental health support worker's certificate. A few participants launched into stories about the practical barriers which were preventing them from completing relevant qualifications.

Some people, on the other hand, responded to this discourse more positively, by arguing that a national qualification in peer support was needed:

In New Zealand, we really love qualifications. And we love, you know, qualifications are valued with money. And it's one of the first things people ask about, you know, what qualification do they have?

So we either need to shift that, the way we honour credentialing in New Zealand, or we create a certificate or a degree or a diploma, that really has a much broader understanding of the work. (Mgr. 3).

This approach, of chasing validation, was adopted with reservations by some participants, as illustrated here. As in journalism (Aldridge and Evetts, 2003), the discourse of health professionalism was seen to be operating as a mechanism of occupational change; it was seen to be challenging the historical nature of peer support. The desire for standardised qualifications, therefore, was often paired with a wider concern not to lose the ‘essence’ of peer support. The most common strategy in response to the health professionalism discourse involved recognition of its influence, while also challenging the basis of the discourse, either wholly or in part. In challenging the health professionalism discourse, two counter-discourses were proffered. It is to these that I now turn.

### *Grassroots Discourse*

As discussed earlier, peer support has its origins in the psychiatric survivor movement’s analysis of ‘patients’ disempowerment in traditional services (Morrison, 2005), and in its calls for mental health services which are based in mutual relationships between mental health consumers. In her early call for such alternative services, Judi Chamberlin noted that nonprofessional, client-controlled services don’t divide people into ‘sick’ and ‘well’, or into ‘helper’ and ‘helped’. They thus allow people to discover that there are no ‘experts’ (Chamberlin, 1977: 63-64). This view of non-professional services rejecting discourses of ‘helping’ and ‘expertise’ was core to the early peer support established in the 1970s and 1980s.

Peer support is now provided formally in New Zealand, in funded and structured programmes run by paid peer supporters and managers, or occasionally by paid managers with trained and supported volunteer staff. In this context, the grassroots vision of a truly non-hierarchical set of services has come under pressure. However, elements of this vision remain intact, where they sit in some tension with the ‘health professionalism’ discourse. This approach was expressed through what I have called the grassroots discourse. It was most strongly expressed in smaller peer support services where staff are not generally qualified with certificates/diplomas in psychology, mental health support work or peer support, but instead work through job-based training, hands-on experience, their own life experiences and what they regularly referred to as ‘common sense’:

A lot of the things that we do, a lot of it is based on life skills, you know, things that have happened to you before and common knowledge and common sense. You can't train a person, really, I don't think, in how to relate to other people. Some people could have twenty years' training and they still couldn't do it. But they might be able to write books on it, but once, you know, make them try and actually do it; it's not going to happen (PSW 4).

The claim that qualifications don't ensure good peer support work, and that some people without academic qualifications are very good at the job, was regularly made by participants in this study. Often this was accomplished through telling stories about people with qualifications who made 'shocking' peer supporters or who lacked confidence in the role, while conversely telling stories about unqualified people who were 'naturals' at peer support.

The subject position taken up by peer supporters within the grassroots discourse is much more appealing than that offered within health professionalism. Within this discourse, it was common for participants to claim authority for life experience and hands-on experience, while disparaging the authority which comes from books. When talking about her role on a mental health advisory committee, the manager of a small service said she was asked by an academic in the group, "What degrees do you have? Oh, from what university?"

And I said "from the university of life". And she was stumped, she didn't know how to respond to that. But you know, that's how I felt about what I brought to that table. I could have had all the degrees in the world but it wouldn't have made me a safe or knowledgeable person. But that lived experience was the asset that got me onto that advisory group in the first place (Mgr. 2).

This subject position was not held in an uncomplicated way, however. The above quote was immediately followed by this manager listing all the diplomas and degrees held by members of her staff, while asserting that workforce development was an important value within her service. She went on to describe the health barriers which had prevented her from finishing her degree.

A tense relationship between the health professionalism and grassroots discourses led to the latter discourse often being articulated defiantly, from a defensive stance, as if the participant was trying to convince themselves of its validity even while articulating it. Statements made within this discourse were often followed, as in the above quote, by the qualifications of the speaker, or other members of his or her service. For instance, one peer supporter suggested

that she was a ‘doing learner’ and had learned more on the job than colleagues who did have qualifications, then switched directly into an account of practical restrictions which had prevented her undertaking a qualification and the fear that new requirements around minimum qualifications might prevent her from continuing in a peer support role (PSW 5). Another peer supporter responded to a question about formal qualifications by interspersing her articulation of the grassroots discourse with a nod to her own desire to gain more qualifications:

Interviewer: Do you think having a formal qualification makes a person a better peer supporter?

PSW 6: No. No I don't. In saying that, I have always wanted to better my education and carry on with my tertiary education, definitely. But I don't believe – anybody can get the concept of recovery if that's what they choose to do. And I think people just have to be approachable and very open to meeting people, seeing people on the same level as themselves. Just being mutual, being relatable, I guess. Yeah. No matter where you've come from, your background, whether you speak English, whether you're whatever. No matter what qualifications you have (PSW 6).

The grassroots discourse was extremely inclusive. People drawing on this discourse regularly asserted that non-academically inclined people – even illiterate people – and members of other socially marginalised groups, could become good peer supporters. At the same time, they claimed an epistemological authority from their lived experience. However, nobody directly referenced the historical origins of this discourse in the psychiatric survivor's movement, and almost everybody used it in interactive and somewhat defensive relation to the health professionalism discourse. What comes through strongly is that this ‘nonprofessional’ understanding of peer support has reduced credibility in the present context, and is losing ground in the contemporary peer support scene.

#### *Transformational peer support discourse*

A third discourse offers a robust challenge to the philosophical basis of the health professionalism discourse, while also taking on board its high regard for education and training. This discourse, which I have called the ‘transformational peer support discourse’, asserted that peer support training was highly valuable and could indeed be transformative. However, formal qualifications in mental health were not usually seen as necessary, and could even be seen as a hindrance. This discourse tended to be articulated by participants trained in one of three peer support models which, with one exception, did not provide NZQA

approved qualifications and are not formally assessed. They are instead delivered through informal workshops and training. This discourse was associated with a very strong conceptualisation of what peer support should be, grounded in psychiatric survivors' conceptualisations, but further developed through a focus on the reframing of experience and the development of robust relationship skills.

One manager described her first experience of peer support training:

I turned up to the training thinking, "oh, well, it's about communication and I know about that stuff. And it's about this and that, and I know about those things". And perhaps was on the first morning a little bit arrogant in my own thinking about what it was going to be. And was completely unprepared for what it actually was, and what it meant to me and how it changed my life (Mgr. 3).

She went on to say that learning her difficult life experiences had intrinsic value – and had built a strength and resilience within her that allowed her to assist others – changed her. It was about turning the notion of 'mental patient' inside out, letting go of diagnostic labels and exploring what was valuable about herself. As a trainer, she had seen the same transformational process with other people. "There's some sort of magic that happens for people" (Mgr. 3).

Within this discourse, peer support education was seen to have much wider applicability than just training former mental health consumers in a set of technical work related skills. In fact, a number of participants said that peer support education should be made available to the wider community:

It's about development of relationships, really. And the responsibility of relationships and mutual responsibility and awareness. And it's also about re-telling your story, using, you know, from a different viewpoint than from a medical viewpoint. So I think Intentional Peer Support training is really good. As a matter of fact I think it's, I think all people that work with people should do a similar sort of training. Because it's more than a peer support approach (Mgr. 5).

Alongside this view, peer support was conceptualised as being much more than standard mental health work, albeit operated from a nonclinical and nonprofessional perspective. Instead it was about mutual learning relationships which could bring about personal transformation for both parties.

Peer support is a very deep thing, you know. And recovery and wellbeing's a very deep thing as well. It's all basically, you know, you could say it's almost like, it's almost like, recovery's almost like a spiritual experience. But it's certainly I would say it's a critical learning experience. It's an experience of true learning. If you look at

learning environments and recovery environments, they're the same thing (Mgr. 5).

This discourse offers peer supporters and peer support managers a powerful subject position from which to speak. Rather than playing catch-up in terms of formal qualifications and expertise, or speaking authoritatively only from the unstable and often disrespected ground of life experience, peer support training offers – in addition to life experience – an authoritative position as knowledgeable and well trained in that most important of human activities – relationships.

And if 80% of what you do is in relationship, I think if peer support workers, I guess our end game is to be exceptionally skilled at relationship, really. If that's one thing we can bring, it's relationships with people (Mgr. 6).

This is a subject position which also positions peer supporters as innovators and leaders, in addition to their role as skilled mental health workers. Starting from the hugely stigmatised subject position of mental health consumer, the peer support movement has developed a training and practice model which can bring great benefits to the wider world.

And the training in peer support and self-care is for everyone, not just for mental health. The fact that it's emerged out of mental health is significant, because we're the ones who maybe have the greatest difficulties in maintaining relationships. But if we can make it work for ourselves, surely it's going to be quite easy for people who don't have the struggles we've had to make it work (Mgr. 6).

This approach runs aground on the lack of official credentialing for peer support, and the consequent tensions raised by the hegemonic status of the health professionalism discourse. Aside from one NZQA level 4 qualification in peer support, largely used by a single organisation, there are no recognised qualifications in peer support within New Zealand. Some rather fragmented efforts by a few providers to create a nationally recognised qualification which would have NZQA level 4 status, based on the principles of this 'deep' form of peer support, have so far borne little fruit. Such attempts have led to some misgivings, as noted by one manager:

For if you look at what is the inherent, inherent basis of peer support, it is something that's unpaid, you know. Is just a mutual relationship between me and you. It's got nothing to do with whether I'm qualified and you're not. And as soon as you start professionalising something, some of that disappears. And what impact will that have on relationships? Because people will, you know, have that: "Well,

I'm a professional and you're not." And what does that do in the end? Will peer support be peer support if we do that? I don't know. I don't know. I don't know. I'm very conflicted about it (Mgr. 7).

The concern was, that by bringing assessment, academic standards and credentialing into peer support training, its transformational nature might be compromised. As in the psychiatric survivor's discourse, the question of whether this is something which can be 'taught' arises? Is this material to be learned, or is it necessary only to create the correct learning environment for people to undergo these powerful experiences?

### **Discussion**

These three discourses value strikingly different approaches to the development of qualifications and training for peer support in Aotearoa New Zealand. The health professionalism discourse suggests that peer support should quickly go down a route of greater accreditation and national standards for education and training, rather along the lines of the Mental Health Support Workers' Certificate. The grassroots discourse resists this trend, holding tight to the historical origins of peer support as mutual aid within inclusive, non-hierarchical relationships. While the transformational peer support discourse draws a middle line between these two approaches in relation to training, it does so with an eye to protecting the radical nature of peer support as grounded in empowering relationships.

Liz Bondi has argued (2004) that counselling went through a process of professionalisation not unlike that which peer support now seems to be embarking upon. Counselling emerged in the 1950s as mutual aid by non-experts, inspired by Carl Rogers' humanistic vision of liberating relationships which were explicitly non-judgemental, non-hierarchical and egalitarian (Bondi and Fewell, 2003; Bondi, 2004). Counselling training was based on the practice based development of existing relationship skills, rather than on extensive academic study. There were no academic pre-requisites for counselling training, for example (Bondi, 2004: 321). Counselling, Bondi notes, thus originated as an avowedly lay practice, and was constituted as something wholly different from a profession (2004: 321).

This has parallels with the way peer support is understood by peer supporters now. Just as psychotherapy was the shadow of counselling at that time, understood as a hierarchical, expertise-based form of practice (Bondi, 2004), counselling is now understood as the shadow of peer support. One peer support manager described the way two trained counsellors found that training



in peer support required them to think quite differently. She said that one of these new peer supporters received negative feedback during training, that he was 'being the counsellor', and needed to move into a less expert driven relationship with his peer (Mgr. 8).

Bondi argues that counselling has been professionalised by three primary mechanisms. The first was the establishment of systems of voluntary self-regulation, which have become increasingly influential and 'necessary' to practitioners. The second was through the establishment of recognised training standards, and procedures for the validation of training courses by academic institutions. These courses have increasingly become formal. Finally, development of a career niche for counsellors, through the establishment of paid counsellors within many institutions, has led to an expectation that counselling should be a remunerated occupation (Bondi, 2004).

Within peer support, the third of these processes is already in place. During the 1990s and 2000s, funded peer support programmes were developed in a number of jurisdictions, such as Scotland (Bradstreet and Pratt, 2010), New Zealand (Scott, Doughty and Kahi, 2011), Canada (O'Hagan et al., 2009), and Australia. Designated service user roles still make up a very small part of the total mental health workforce in New Zealand – approximately 1% of the District Health Board workforce and 4% of the NGO workforce (O'Hagan 2011: 23), but the numbers are growing quickly. The Ministry of Health's latest service development plan for mental health and addictions sees peer support as an essential part of services in New Zealand, which suggests that this growth will continue (MoH, 2012). There are also changes occurring in relation to the first two processes, as seen in this article.

The disciplinary regime of occupationalism is operating within peer support in a manner similar to that described by Fournier for the professions (Fournier, 1999), even though this occupation remains underpaid and relatively stigmatised. The grassroots discourse already is operating from a defensive position, and the health professionalism discourse is gaining ground. As counselling did, there is the possibility that peer support might change in character as these new 'facts on the ground' take hold. As Mgr. 6 asked, 'Will peer support be peer support if we do that?' Interestingly, the niche in which peer support operates was suggested by one counsellor Bondi interviewed to be a necessary and constantly regenerating one.

[Counselling] will fossilise, just like other professions fossilise. And after it there'll be another wave of people who call themselves

befrienders or something like that. And there'll be cowboy chaos in that area for a while and then... that will begin to professionalise and it will fossilise too, and then there'll be another [...] vehicle for unlocking the talents of the population (Cited by Bondi, 2005: 511).

The challenge for peer support is to prevent the fossilisation of the practice, while supporting some training and processes of standardisation. In this respect the transformational peer support discourse has much to offer, with its vision of transformative practice sustained through alternative, holistic, training and education practices. It is this discourse which is being put into practice in the mental health and addictions consumer and peer workforce competencies, with their focus on mutuality, experiential knowledge, authentic relationships and human rights (Te Pou, 2014a). The challenge is to implement these competencies in a way that respects the historical constitution of peer support as fluid, relational, equitable and as non-hierarchical as is possible.

## References:

- Adame, A.L. and Leitner, L.M. (2008) Breaking out of the mainstream: the evolution of peer support alternatives to the mental health system. *Ethical Human Psychology and Psychiatry* 10(3): 146-162.
- Aldridge, M. and Evetts, J. (2003) Rethinking the concept of professionalism: the case of journalism. *British Journal of Sociology* 54(4): 547-564.
- Anthony, W. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal* 16(4): 11-24.
- Archibald, M.E. (2007) *The Evolution of Self-Help: How a Health Movement Became an Institution*. New York: Palgrave Macmillan.
- Bondi, L. (2004) 'A double-edged sword'? the professionalisation of counselling in the United Kingdom. *Health and Place*, 10, 319-328.
- Bondi, L. (2005) Working the spaces of neoliberal subjectivity: psychotherapeutic technologies, professionalisation and counselling. *Antipode* 37(3): 497-514.
- Bondi, L. and Fewell, J. (2003) 'Unlocking the cage door': the spatiality of counselling. *Social and Cultural Geography* 4(4): 527-547.
- Bradstreet, S. (2006) Harnessing the 'lived experience': formalising peer support approaches to promote recovery. *The Mental Health Review* 11(2): 33-37.
- Bradstreet, S. and Pratt, R. (2010) Developing peer support worker roles: reflecting on experiences in Scotland. *Mental Health and Social Inclusion* 14(3): 36-41.
- Brown D.K. and Bills, D.B. (2011) An overture for the sociology of credentialing: empirical, theoretical and moral considerations. *Research in Social Stratification and Mobility* 29(1): 133-138.
- Campbell, J. (2005) The historical and philosophical development of peer support programs. In S. Clay (Ed.), *On Our Own Together: Peer Programs for People with Mental Illness* (pp. 17-64) Nashville: Vanderbilt University Press.
- Chamberlin, J. (1977) *On Our Own: Patient Controlled Alternatives to the Mental Health System*. Lawrence, MA: National Empowerment Center.

- Chamberlin, J. (2004) User-run services. In J. Read, L. Mosher and R. Bentall (Eds.), *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia* (pp. 283-290) London: Routledge.
- Clay, S. (2005) *On Our Own Together: Peer Programs for People with Mental Illness*. Nashville: Vanderbilt University Press.
- Deegan, P. (1988) Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal* 11(4): 11-19.
- Doughty, C. and Tse, S. (2011) Can consumer-led mental health services be equally effective? An integrative review of CLMH services in high-income countries. *Community Mental Health Journal* 47(3): 252-266.
- Everett, B. (1994) Something is happening: the contemporary consumer and psychiatric survivor movement in historical context. *The Journal of Mind and Behavior* 15(1-2): 55-69.
- Fournier, V. (1999) The appeal to 'professionalism' as a disciplinary mechanism. *Sociological Review* 47(2): 280-307.
- Mead, S., Hilton, D. and Curtis, L. (2001) Peer support: a theoretical perspective. *Psychiatric Rehabilitation Journal* 25(2): 134-141.
- Mead, S. and MacNeil, C. (2006) Peer support: what makes it unique? *International Journal of Psychosocial Rehabilitation* 10(2): 29-37.
- Mental Health Commission (1998) *Blueprint for Mental Health Services in New Zealand. How things need to be*. Wellington: Mental Health Commission.
- Ministry of Health (2012) *Rising to the Challenge: The Mental Health and Addictions Service Development Plan, 2012-2017*. Wellington: Ministry of Health.
- Morrison, L.J. (2005) *Talking Back to Psychiatry: The Psychiatric Consumer/Survivor/Ex-patient Movement*. London: Routledge.
- Nelson, G., Janzen, R., Trainor, J. and Ochocka, J. (2008) Putting values into practice: public policy and the future of mental health consumer-run organizations. *American Journal of Community Psychology* 42(1-2): 192-201.
- O'Hagan, M. (2011) *Peer support: Mapping the Terrain*. Wellington, New Zealand: Careerforce.
- O'Hagan, M., McKee, H. and Priest, R. (2009) *Consumer Survivor Initiatives in Ontario: Building for an Equitable Future: Report for CSI Builder Project*. Toronto, Ontario: Ontario Federation of Community Mental Health and Addiction Programs.
- Ontario Ministry of Health. (1993) *Putting people first: the reform of mental health services in Ontario*. Toronto: Ontario Ministry of Health.
- Orwin, D. (2008) *Thematic Review of Peer Support: Literature Review and Leader Interviews*. Wellington: Mental Health Commission.
- President's New Freedom Commission on Mental Health. (2003) *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-0303832. Rockville, MD: U.S. Dept. of Health and Human Services.
- Scott, A.L., Doughty, C. and Kahi, H. (2011) *Peer Support Practice in Aotearoa New Zealand*. Retrieved 17 July 2015 from the World Wide Web: <http://www.hdc.org.nz/media/199065/peer%20support%20practice%20in%20aotearoa%20nz.pdf>.
- Scottish Executive. (2006) *Delivering for Mental Health*. Edinburgh: Scottish Government.
- Smith L.T. (1999) *Decolonizing Methodologies: Research and Indigenous Peoples*. Dunedin: University of Otago Press.
- Strauss A.L. (1987) *Qualitative Analysis for Social Scientists*. Cambridge: Cambridge University Press.

- Te Pou o Te Whakaaro Nui (2014a) *Competencies for the mental health and addiction service user, consumer and peer workforce*. Auckland: Te Pou.
- Te Pou o Te Whakaaro Nui (2014b) *Service user, consumer and peer workforce: A guide for planners and funders*. Auckland: Te Pou.
- Timmons, S. (2011) Professionalization and its discontents. *Health* 15(4): 337-352.
- Willig, C. (2008) Foucauldian discourse analysis. In C. Willig (Ed.), *Introducing Qualitative Research in Psychology: Adventures in Theory and Method* (pp. 112-131) Maidenhead: Open University Press.

**Acknowledgements:** I would like to thank Mary O'Hagan, Frank Bristol, Andrew Cook, Tiina Vares, Terry Austrin and Angie Rippon for helpful comments on earlier drafts of this article. I would also like to thank Carolyn Doughty and Hamuera Kahi for help with the data collection stage of this project. Finally, thanks go to the generous participants in this study. This study was funded by the University of Canterbury College of Arts.

*Dr. Anne Scott* is a sociologist in the Sociology and Anthropology Dept. at the University of Canterbury. She is a specialist in sociology of health and illness, and has done previous work on genetic testing, biobanking, alternative medicine, mental health and community informatics. [A.Scott@canterbury.ac.nz](mailto:A.Scott@canterbury.ac.nz)